THE ARMY NURSE CORPS NEWSLETTER

"Ready, Caring, and Proud"

Volume 05 Issue 9 ***July 2005***

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Message from the Chief

Greetings and I hope that each of you found a special way to celebrate the birth of our Nation over the 4th of July. I hope you remembered your individual contributions to our Army help sustain the American way of life for our citizens and lift America as a land of opportunity to the many immigrants who still seek a life here. You are beacons for the rest of the world—I hope you realize that!

We had an excellent session in San Antonio with the AN officers, Active, Reserve, and Guard, who attended the AUSA Medical Convention. The ability to get all three groups together and discuss the challenges that are unique or shared was a great education for all of us. We are actively working with the Reserve on the need to transition their ADN staff into BSN prepared officers and the coalition of all three groups on this issue will make the solution of this dilemma much easier. I am grateful for everyone's active involvement as we stress the requirements of the professional nurse--the pursuit of excellence in clinical practice, education, research and leadership.

A first this year, is the active engagement of the clinical nursing consultants with their Medical Corps colleagues. These officers met with one another in San Antonio to begin that working relationship in preparation for their combined efforts for the Officer Distribution Plan (ODP) recommendations to the AMEDD general officers (the Dec ODP plans for requirements for the upcoming summer). This approach expands the responsibilities of our nursing consultants. It will contribute to the AMEDD goal for assignment of a complete team of professionals necessary to provide high quality and safe patient care. Although the MC consultants make assignment decisions, it is NOT my intent that the consultants take on the role of our ANC branch officers, who assign individuals. These consultants, both ANC and MC will meet again in Sep for planning and then in Dec for the ODP. I very much appreciate the support of the local MTFs to insure these consultants are available for this important work. I am very pleased with the increased teamwork I am seeing with our MC colleagues. I believe that the morale of our combined staff and the quality of care will both benefit from this modified process.

Finally, I want you to know that we are seeking volunteers to continue the efforts of the original six Army nurses who volunteered and deployed into theater to address trauma care and the establishment of a trauma registry. This trauma effort has become joint, so now we share this responsibility with our Air Force and Navy nurse colleagues. We need two Army nurses this fall. While in theater, these nurses have served as the resident experts on trauma systems for their hospitals; advised physicians, nursing and pre-hospital care teams on "how it works;" capturing the data on the PI projects to document how and when it doesn't: and identifying improvements. The volunteers for the third rotation will receive enhanced training on trauma systems, trauma CPGs and trauma PI before they arrive at the CRC. Eligible (Non-PROFIS, CPT(P) or MAJ) Emergency, Critical Care or Med-Surg nursing personnel with trauma experience should submit a brief letter of interest to Colonel Bruno, after discussing your intentions with your Chief Nurse, at barbara.bruno@amedd.army.mil.

I am reminded whenever I talk with our ANCs, that both the ones who deploy and those who are caring for injured service members need to talk about their experiences, concerns and frustrations. Please be there for one another—if we can't care for one another, caring for strangers becomes even more difficult.

I remain honored to serve with you. GSP

The ANC Newsletter is published monthly to convey information and items of interest to all Army Nurse Corps officers. If you have an item that you feel would be of interest to your fellow ANCs, please e-mail the articles to MAJ Eric Lewis. The deadline for all submissions is the third week of the month prior to the month you want the item published. All officers are eligible to submit items for publication. We reserve the right to review and edit any item submitted for publication.

Kudos and Publications

Congratulations to COL(P) Robin Umberg, AN on her promotion to Brigadier General, Chief of Clinical Operations, 3rd MEDCOM.

Congratulations to COL Lenore Enzel on her selection to the Board of Directors, Vietnam Women's Memorial Foundation, Inc.

"Congratulations to MAJ Veronica Villafranca, AN for being selected by the Arizona State University (ASU) Faculty in the College of Nursing to receive the Outstanding Representative of Professional Leadership Award during the ASU Graduation Ceremony on May 13, 2005. MAJ Villafranca was recognized for her commitment and important contributions to strengthening the future of the nursing profession."

Kudos to Major Jacqueline Sheehan, CRNA for recent publication in the June 2005 edition on Military Medicine, A Case Report: Malignant Hyperthermia and the Trauma Patient.

Well Done!! LTC Irma Cooper, AN, CDR of the 113th Medical Company, Combat Stress Control, recently published an article *When Leishmaniasis Strikes,* in Advance for Nurses Online at **http://nursing.advanceweb.com/common/Editorial/Editorial.aspx?CC=**

Thank you to COL Enzel for sending information on the American Women in Uniform Website at http://coelacanth.aug.com/captbarb/. Check it out.

We want to give late but hearty congratulations to **CPT Doug Elmore** who was acknowledged as one of California nursing's brightest stars. Several California nurses were celebrated during the fifth annual Nursing Excellence Awards gala dinner Nov. 5, 2004 at the Fairmont San Jose. About 350 attendees gathered to honor the accomplishments of 48 nurses, from which one winner was selected from each of eight categories: Advancing the Profession, Clinical Care, Community Service, Innovation/Creativity, Leadership, Mentoring, Patient Advocacy, and Teaching.

CPT Elmore was the recipient of the award for Clinical Care. **Below is an excerpt taken from Nurseweek.com about CPT Elmore.** (You can read the full article online at http://www.nurseweek.com/news/Features/04-11/ExcellenceAwardWinners_CA_print.html.)

Doug Elmore says when he was wounded in Afghanistan as an Army Reserve Nurse Corps officer, he had "the best seat in the house to observe the quality of care that EMTs, LVNs, and RNs gave me. All of their teaching and shared experience paid off."

Elmore knows about excellent medical care. He began his own health care career as a registered respiratory therapist at UC San Diego Medical Center, focusing primarily on infants and children. Deciding to become a nurse — "I knew I wanted to offer more to patients" — he graduated in 1994, remaining with UCSD, and transferring to the adult surgical trauma ICU there. He gained experience in all areas of critical care nursing, including resuscitation, intubation, and organ transplants. He also participated in research and training of medical personnel.

Deployed to Afghanistan in 2002, he received many medals, including the Purple Heart, becoming the first nurse since the Vietnam War era to win this honor. He said laughingly that this may be why he became "the sentimental favorite" to win a Nursing Excellence Award.

He has since been "demobilized" to civilian status following seven months of rehab and physical therapy. He continues to lecture, train, and provide expert patient care. He is hoping to gain acceptance into a nurse practitioner program next year and to being the best husband, father, and nurse I can be."

Paolucci, M., and Bannerman, B., (2004) *Star Power: Nursing Excellence Awards Celebrate Profession's Finest,* Nurseweek.com, 15 November 2004.

News from Around the Army Nurse Corps and the World

News from the Office of the Army Nurse Corps

All ANCs that have been awarded the 9A designator please check your ORB to ensure it is there. If it is not please contact COL Harris at HRC to have this corrected. Thank you.

Mobile Training Team, Kabul, Afghanistan by LTC Susan Anderson

MAJ Brian Benham and I were a part of a Mobile Training Team sent to Kabul Afghanistan. Tremendous degradation in the healthcare facilities, staff and infrastructure has occurred due to 30 years of war and the Afghanistan National Army (ANA) medical staff has had minimal to no exposure to technological and academic advancements in medicine during this time. Our stated goal from the U.S. Security Assistance Training Management Office (SATMO) was to provide an invaluable wealth of knowledge and expertise in the development of a new military medical system. We were to train command selected ANA hospital senior leaders/department chiefs and their deputies on new or revised medical treatment protocols related to equipment and supplies on hand in the ANA hospital. Our team consisted of a radiologist, an emergency medicine physician, a pharmacist, a physician's assistant, a medical maintenance specialist, a nurse anesthetist and a nurse educator/critical care nurse.

What we found when we arrived was a country that was obviously dealing with the aftermath of war. The basics that we take for granted such as running water, sewage, and electricity were nonexistent or minimal at best. The roads of Kabul, a city of approximately 3 million people, were torn up and full of pot holes the size of a jeep. On arrival we were briefed on the status of the health of the Afghan people. Their infant mortality is one of the highest in the world and their average life expectancy is 45 years. With this in mind, we were told that the Afghanistan National Army Hospital and clinics were the premier healthcare centers for the country. We were given a tour of the hospital escorted by the Chief Nurse of the Afghanistan National Army, General Razia. The building was built in 1978 by the Russians and had not been renovated since. There were holes in the walls and windows from mortar shells. The centralized heating system did not work. Water line breaks and power outages were common. The Russian management style of centralized control was firmly entrenched in the logistical and supply system. Caregivers were asking for supplies that we found locked in warehouses behind the hospital. The concern voiced when we asked why the supplies weren't being given out is that there might not be any more to replace what was used. The nursing staff is currently practicing nursing care equivalent to that found in the United States in the 1960s. There is no nursing autonomy. They perform no patient care duties without physician orders. Like the United States they are experiencing a nursing shortage but the reason is very different. During the reign of the Taliban, nursing programs were forbidden and there was no health care education for women. The nurses work 24 hour shifts, three to four days a week.

LTC Anderson with Afghanistan National Army Nurses. General Razia is standing on LTC Anderson's left.

In spite of these adverse conditions, the nurses manage to provide quality patient care. They work constantly to ensure patient care areas are as clean as they can be. They are eager to move forward to a more modern model of healthcare and were most interested when we described our healthcare system. The nurses were very eager to learn and during both lecture and hands on training, were very engaged. One of the main reasons for the desire for the advancement of nursing is General Razia. She has been at the forefront in the quest for better conditions for women. As the Chief Nurse of the Afghanistan National Army, she is not only in charge of all of the nurses, but she is in charge of all female workers who work for the ANA. She has established day care centers and women's health centers. She invited us to thoroughly assess the healthcare system and make suggestions for change that she would implement.

There is a definite need for further intervention to help the Afghanis bring their healthcare system out from the ruins of war to the 21st century. They will benefit greatly from follow up education and support. They are a proud and hardworking people who have come through a lot but still have a long way to go.

ANCs at the American Organization of Nurse Executives Annual Meeting by COL Stephanie Marshall

American Organization of Nurse Executives (AONE) 38th Annual Meeting was held in Chicago on April 15-19. I attended as the President of the Hawaii Chapter, AONE and was glad to see some of my military colleagues also in attendance. The conference was attended by over 2500 nurse leaders across the country. ANC's own - COL Anita Schmidt gave the final plenary presentation on the day within the theme "Celebrating Military Nursing". She shared with the group her story of deployment in Iraq and chronicled the lives of military nurses in service to our country. She spoke to the level of units deployed and the challenges the nurses faced while caring for soldiers in austere conditions. She was awarded with a standing ovation. The President of AONE asked all those who have served and are currently serving to stand, and were recognized again with lengthy applause. Many attendees stopped those in military uniform to thank them, talk about a loved one deployed or recalling their experiences.

I also would invite all Army Nurse Corps leaders to take a moment and access the AONE website- www.aone.org . AONE's strategic plan for 2005-07 is well articulated along with their guiding principles. A focus within the guiding principles for future health care delivery stems from the work of Dr Linda Aiken, whose work on the relationship between nursing education and patient outcomes set the stage for AONE 's support to the baccalaureate degree as the desired educational level for the registered professional nurse of the future. The chapter leaders strongly endorsed this goal and will begin to work a plan nationally, regionally and locally to promote this within the academic and hospital settings. Exciting news! You will also find nurse executive competencies recently released on the website and several upcoming AONE-sponsored conferences. Many of the board member and regional leaders are former military nurses and have been instrumental in this framework. Photo captures Army Nurses in attendance with COL Schmidt after her presentation along with an Air Force colleague. Well Done – COL Schmidt!!

Memorial Day Experience by COL Lenore Enzel

I was lucky enough to be asked to speak in Washington, D.C. at the Vietnam Women's Memorial on Memorial Day. I spoke about the sacrifices made by Army Nurses in Vietnam and today in Operations Iraqi Freedom and Enduring Freedom. I also spoke about CPT Gussie Mae Jones, the WBAMC Critical Care Nurse who was PROFIS'd to the 31CSH and died in Baghdad on 7 March 2004.

The day prior to my speech, I had the opportunity to be a passenger on one of the motorcycles that participated in Operation Rolling Thunder. This was the eighteenth year that bikers from all over the nation came to Washington, D.C. to show their support for America's military and our POWs & MIAs. Estimates are that there were between 250,000-300,000 motorcycles! It was a truly awesome experience. I wanted you all to know how grateful the American people are for your dedicated service. The parade route was lined 5-6 deep and the gratitude I felt from the onlookers was obvious. Think about spending next Memorial Day in DC. Bring your families and let them learn about those who went before us. It was an amazing and a touching weekend and I will fondly remember it always.

News from ROTC by CPT Tanya Foster

As the Brigade Nurse Counselor for 13th Brigade, Western Region (ROTC) at Fort Lewis Washington I cover a large geographic area that includes Washington, Oregon, Hawaii, Alaska, Idaho, Montana and Guam. Within my area I provide counseling to over 120 college nursing students that participate in ROTC. As the sole "expert" for nursing at the Brigade I answer questions, inform and educate the

cadre; assist in recruiting and retention, scholarship and prospect management, and countless other tasks. As my time here comes to an end, I have learned that the biggest and most important part of my job has been counseling and mentoring the nursing cadets. Looking back at the past two years I realize counseling these cadets is nothing like the counseling I did as a preceptor or as a Head Nurse. As a Brigade Nurse Counselor I am part counselor, mentor, parent and friend. I have found effective counseling requires developing a counseling approach to uniquely fit each student and his/her situation, i.e. I do not counsel my freshman students the same way that I counsel my seniors. In counseling my cadets I use a counseling framework I like to call "Building Your House." In this framework I equate the college/ROTC experience to building a new home. The first step is what I call "finding your dirt." Usually this occurs during the high school senior or college freshman year. "Finding your dirt" involves figuring out where you want to build and what kind of house you want to end up with. For the student this is figuring out where they want to go to school and what they want to be when they graduate from college. Some of the students already know they want to be a nurse and in the Army. Unfortunately, not everyone comes to this decision so quickly and this is where I come in to help the student figure out what they want to do upon graduation. Army? Nurse? Fireman? Astronaut? - "finding their dirt!"

The second stage is "building the foundation." A strong house relies on building a sturdy foundation. This is a critical time; everything the cadet does will build upward from this, good or bad. The keys to a strong foundation are four important "corner stones." These are study habits, time management, goals/priorities and self care. The first cornerstone, a cadet's study habits, needs to change and adapt to the college structure. I think it is important that they learn how, what and when to study. It is getting the most bang for their buck. I encourage them to try new ways of learning and finding ways to make things stick. I encourage them to figure out what kind of learner they are. I urge them to use the resources that are available: instructors, tutors, study centers and study groups. The next cornerstone is time management. The number one complaint I hear from cadets is they never have enough time. I encourage them to use a planner, PDA or calendar to keep everything in order. I also encourage them to do an exercise that I call time mapping. I have them get a large sheet of paper (usually a paper grocery bag as it is cheap and free) and I have them create their map. It is a large grid that has seven days across and 24 hours down. There is a box for each hour. I believe to be successful there are really only five things the cadet "needs" to do. Eat, sleep, go to class, do PT and study. Obviously there is more to life then these things but this is a start. I have them fill in the boxes on the grid when all of these things will occur. I also encourage them to schedule at lease six hours for sleep and also schedule in at least one fun activity. Through this process they are able to visualize where their time is and where it is going. I have them look at the blank boxes and consider how they can best use the time they have open. This approach may seem forced and structured, but it needs to be initially until managing time becomes routine, without having to use a "grocery bag." I encourage them to multitask, and make the best use of their time. My third cornerstone is priorities and goal setting. It is important for cadets to know what they are striving for, their ultimate goal. I have them make as many short term goals as they need to keep them motivated. The number of "marks on the wall" is different for every cadet. Knowing their goals is important in setting their priorities. College is full of activities that may take them away from their ultimate goal of becoming an ANC officer. I encourage them to enjoy as many activities as they can handle, as long as it does not detract from meeting their goals. The last cornerstone is self care. College is a very stressful and busy time. I think it is important that the cadet understand, at the very least, two things about themselves. One is what motivates them and what helps them relieve stress. I believe it is important to stay motivated and also to have a way to "shake it off" when things get to heavy.

CPT Tanya Foster surrounded by pictures of the many nurse students enrolled in Army ROTC in the 13th Brigade(WA, ID, MT, OR, AK, HI, GU).

The third stage of "building the house" is the structure and the framing; generally this occurs in the junior year. This is the real "meat" of my counseling program. This is usually where the learning curve is steepest and where the greatest testing, shaping and development occur. During counseling with the junior cadets we discuss LDAC, the summer assessment course at Fort Lewis, NSTP and the clinical requirements at the MTF's, and assignment choices. I take the time to answer any career oriented questions concerning specialty courses, masters programs and first duty assignments. I also focus on repairing any "cracks" that may have appeared or are starting to appear i.e. poor grades in class or difficulty with time management.

The final stage is "putting on the roof and finishing touches." The student's senior year is the culmination of everything they have been working on for the past four years. I am careful to remind them that their house is not finished until they graduate and pass their NCLEX. In counseling the seniors I find myself doing more listening then speaking. I am listening for what the cadet needs from me at this point. I try and offer guidance about what their future holds. I answer questions, address doubts and anxieties and give encouragement for them to finish strong. I know that this job has taught me many things; one of the most important is how to counsel and mentor effectively. I have worked hard to include things in my counseling that will make my cadets successful not only in college, but work and life there after.

News from the Reserve Component

If you are a Nurse Corps Officer in the Reserve or National Guard we would like to hear from you. Please send your submission to eric.lewis@amedd.army.mil. Thank you for all you do!

News from the Joint Commission on Healthcare Organizations

What is a Joint Commission Surveyor ***Really*** Like (once the stage lights have been turned off and the audience has gonehome)?

The past few months have been busy ones for the fellows at the Joint Commission. Each has had the opportunity to observe several surveys at both civilian and army medical facilities. Toward the end of July LTC Melton and I will be moving to our follow-on assignments, and LTC Sharon Sterling and MAJ Christine Kramer will take our places.

LTC Melton and I are often asked the question, "What is the most important thing you've learned while observing a survey"? It is difficult to choose one item; however, here are some thoughts stimulated by that question.

The strength of leadership and the culture of the organization are remarkably apparent within the first few hours of survey onset. Day one of the survey is very important since the surveyors gain an understanding of how the organization responds to issues, or potential issues; how information is communicated among staff; and whether the organization views the accreditation process as a means to improve and provide safe patient care within their system, or as an inspection they must pass while avoiding any recommendations for improvement. Some organizations "circle the wagons" early on, over-react to an issue that has not been completely explored (and may or may not result in a requirement for improvement (RFI). Other organizations calmly answer questions and clarify how their particular organization approaches an issue. The latter is generally more successful. Peter Drucker once said, "Leadership is not magnetic personality - that can just as well be a glib tongue. It is not "making friends and influencing people" - that is flattery. Leadership is lifting a person's vision to high sights, the raising of a person's performance to a higher standard, the building of a personality beyond its normal limitations." If the organization's leaders are not doing these things, the surveyors will know it extraordinarily quickly.

It is very noticeable when an organization does *not* routinely employ the Tracer Methodology as part of their performance improvement system. The look of astonishment on the faces of leaders at all levels of an organization, as seen during survey related to the sometimes comical, if not downright scary. Findings unearthed during tracer activities will tell the tale whether the organization has been seriously attempting to improve care using tracers or not. Some organizations run tracers seemingly to confirm that "the way we do it here is just fine", while others are looking for weaknesses in systems which, when identified, can be addressed to improve quality of care; the difference between the two will be apparent to the surveyor.

The argument that "we are special here" is rarely a valid one. One civilian organization indicated that their incomplete competency files were due to a high use of contract employees the organization was required to employ to meet critical patient care needs; we in the military, better than most, see through that argument. If change in the form of high staff turnover rates is an organization's constant state---as is the case with military healthcare, the organization must take that constant into consideration when constructing its continuous competency assessment program. The risk of using the "we are special" argument to address any issue is this: the surveyor likely has encountered many other "special" organizations that have encountered the self-same issue being presented, and those organizations have managed to construct their care processes to ensure patient safety is maintained and meet Joint Commission standards, all without incurring astronomical cost to do so.

Surveyors seek to understand. They do not know an organization when they step into it. If a process does not make sense to them they ask questions. Organizations do better when their employees respond by asking the surveyor to clarify the focus of their concern and direct responses focused at attenuating those concerns. If a good process is in place, it will often speak for itself as the surveyor learns more about it. Long dissertations that avoid the issue at hand are tiresome, even to the most energetic surveyor.

We have noted that surveyors want an organization to do well. The stereotype of the Joint Commission surveyor as the "hatchet man" (or woman) is largely invalid. Behind closed doors the surveyors are NOT conspiring to see how they can score their findings to achieve the most number of requirements for improvement! You would be surprised to learn how often the opposite is true.

Give the surveyor some space! Some organizations insert themselves into the surveyor's closed door planning sessions, working lunches, etc. Resist the urge to interrupt the planning sessions unless you have been specifically asked to immediately provide information to the

surveyors. When asked for clarifying information, make it a practice to ask when the surveyor would like the information. If the response is "by the end of the day", don't stress—they actually mean by the end of the day! There is a fine line between being responsive to the surveyor's requests or intrusive. On two survey observations in particular, the level of intrusiveness was pervasive. Contrary to popular belief, surveyors are human and periodically do need to use the restroom (un-chaperoned, of course), or just have a few moments reprieve from being on the JCAHO stage!

In short, Healthcare organizations are struggling with similar issues. It is refreshing to have had the opportunity to compare and contrast civilian and military healthcare systems. We in the military, by and large, compare very favorably to our civilian counterparts and should be proud of the vital service we provide to our men and women in uniform.

New items of interest on the JCAHO website include:

Field reviews of proposed standards related to disaster responsibilities/privileging (Give your input NOW to the Joint Commission BEFORE the standards are finalized):
http://www.jcaho.org/accredited+organizations/field_reviews.htm

JCAHO's 2006 National Patient Safety Goals:
http://www.jcaho.org/accredited+organizations/patient+safety/npsg.htm

Latest guidance regarding the "Do Not Use" abbreviation list (excellent resource—the requirements changed earlier this year).
http://www.jcaho.org/accredited+organizations/06_goal2_faqs.pdf

Joint Commission International Center for Patient Safety
http://www.jcipatientsafety.org/

And last, but not least, This Month at the Joint Commission—a lot of links to newly posted information.
http://www.jcaho.org/about+us/news+letters/this+month+/this+month/may+2005.htm

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Research Spotlight

Serendipity in Research and Practice: Nurturing Imagination and Inquiry by Colonel Ric Ricciardi, USUHS

How many times have we heard the expression "I just happened to be in the right place at the right time?" Did you ever wonder, what were the circumstances that put you in that place at that time? Was it a matter of planning, luck, coincidence, random chance or wisdom? In scientific research, discoveries are often made when the investigator stumbles onto something useful while looking for something else. This is commonly referred to as serendipitous discovery. The first mention of the word serendipity occurred in 1754 when British author Horace Walpole boasted about a discovery he made by saying "this discovery is of a kind I call serendipity." He went on to explain that in an ancient fairy tale named *The Three Princes of Serendip,* three princes traveled the country and were constantly making discoveries of the world around them, by accident and sagacity, which they were not in quest of.

This new word filled a gap in the language of scientific discovery, because it provided a distinction between a "serendipitous" discovery and a discovery that occurred due to luck, coincidence, or chance. Serendipitous discovery then is more than just luck or chance; it is an active process that requires curiosity, openness to unexpected and previously unseen observations, and the flexibility in thinking that frees you to explore new directions. Serendipity builds on established knowledge, and a willingness to constructively exploit whatever circumstances we may encounter. Thomas Jefferson could have been talking about serendipity, when he said, "I am a great believer in luck, and I find the harder I work the more luck I have."

Sir Alexander Fleming made one of the most famous serendipitous discoveries. During the course of an experiment, he noted the lack of growth of Staphylococcal bacteria in a Petri dish. Molded breadcrumbs had accidentally fallen into the Petri dish, and rather than throwing away his 'failed experiment', Fleming observed that something about the moldy bread had antibacterial properties. Penicillin, which has saved millions of lives since World War II, was thus discovered serendipitously.

Serendipitous discoveries are not limited to the laboratory or research setting; they also occur in our clinical practice, and in fact serendipity may be an important component of the art of nursing practice. For example, we may identify a clinical practice pearl related to a physical examination technique or a solution to a field problem that seemed to occur by chance while caring for a soldier or family member. If we allow our minds to wander a little, creative ideas and useful inventions may also emerge while driving home after work, walking in our neighborhood, or during deployments. What marks the profound observer from the casual one is the ability to see a pattern, association, or implication that had previously gone unnoticed. For example, in the 1940s, the Swiss inventor George deMestral got the idea for Velcro from the burrs that stuck to his pants while he was walking his dog. According to Louis Pasteur, "Chance favors the prepared mind." During the path to discovery, accidents will happen and things will go unplanned, and in the course of such events, the ability to see the potential and make constructive use of them is what characterizes a prepared mind.

The diversity of practice populations, settings, and colleagues offers Army Nurses abundant opportunity for serendipitous discoveries in health promotion and prevention, diagnosis and treatment of disease, casualty care, and leadership strategies. As we interact with a diverse range of colleagues, these interactions can produce unforeseen opportunities for collaboration and for serendipitous results. Individuals with different areas of expertise and perhaps even different priorities come together by chance or by design, and discover that the synergy created through their collaboration leads to a different definition of the problem, and offers solutions that would not have emerged independent of their collaboration.

Serendipity, though, is not a passive process; it requires inquisitiveness, flexibility, openness, creativity, a willingness to make mistakes, and a tolerance for ambiguity, founded upon a high degree of knowledge of one's discipline, a passion for discovery, and a readiness to seize upon chance events. Lack of time for reflection, the absence of spontaneity in our lives, and complacency of spirit can all limit serendipity in practice and research. The paradox of serendipity is that you want to have a good enough idea of what you are looking for to be surprised when you find something else of value, while at the same time, you want to be ignorant enough of your end point that you can entertain alternative outcomes. So offer yourself and all those around you the gift of serendipity—the freedom to 'wander' and to 'wonder' if….

> "The seeds of great discovery are constantly floating around us, but they only take root in minds well prepared to receive them"
> **Joseph Henry**

Colonel Ric Ricciardi, rricciardi@usuhs.mil, Uniformed Services University of the Health Sciences
Phone: 301 461-7109

Further readings:

Merton, R.K. & Barber, E. (2004). *The travels and adventures of serendipity: A study in sociological semantics and the sociology of science*. Princeton University Press.

Rescher, N. (2001). *Luck: The brilliant randomness of everyday life*. University of Pittsburgh Press.

Roberts, R. (1989). *Serendipity: Accidental discoveries in science*. Wiley Publishers.

New PhD Program at Duke University

Our website is activated: http://www.nursing.duke.edu/page/phd_main . If you have not reviewed our site, please take this opportunity to do so. Applications will be accepted on-line by the Duke University Graduate School. http://www.gradschool.duke.edu/ for the Fall 2006 class beginning in August 2005. All materials must be received by December 31 and those received by December 1 will pay a discounted application fee. Admissions occur in fall semester only. Information session will be held: August 22, 2005 at 5:00 pm. POC: Marti Doyle, Coordinator of PhD Program Development, Duke University School of Nursing, DUMC Box 3322, Durham, NC 27710, 919.681.3871

USUHS Medical Executive Skills Training Course

"Critical Decision Making for Medical Executives: Keys to Improving Health Care Delivery" is an advanced-level course offered by USUHS to educate military health care professionals in the tools and methods needed to continuously improve high-quality health care systems. The course supports the Congressional mandate that health care leaders receive training in health care management. With the establishment of the National Quality Management Program, medical executives are accountable for clinical effectiveness and efficiency in the use of health care resources at their facilities. This course focuses on improvement in the quality and cost efficiency of clinical practice and population health outcomes through evidence-based decision making.

The course provides an overview of current approaches to the assessment and improvement of health care delivery in the DoD and civilian managed care environments. Emphasis is placed on the analytic methodologies that support decision-making by medical executives, and the evaluation of processes that improve health status of the patient and minimize resource costs.

The course, delivered approximately five times a year to 4 CONUS multi-service markets and 1 OCONUS market, consists of a combination of pre-course distance learning modules, in-class lectures and discussions, web-based tools workshop, and small group case study exercises. A pre-course survey and assessment of participants is conducted via distance learning. On the final day of the course, the afternoon session involves a scenario-based training exercise integrating the methodologies covered during the week and a post-test evaluation. This group workshops and exercises give participants the opportunity to reflect on current issues and problems encountered by medical executives, integrate what they have learned from the course and to exchange ideas. Who should attend? If you are an O4/O5/O6 and are a leader in the Military Health System, this course is for you. Please logon to: http://medxellence.usuhs.mil/nominations.asp to submit a nomination. For more information, visit us on the web at: http://medxellence.usuhs.mil Nominees are accepted 90 days before each course. Upcoming Course: 24-28 October 2005 Keystone Resort Keystone, CO

News from the Consultants

Community Health Update by LTC Colleen Hart

New Assessment Tool for Community Health Nursing Services

A team of Community Health Nurses (CHNs) has collaborated with the Proponency Office for Preventive Medicine (POPM) to develop an online public health nursing practice self-assessment instrument. This instrument is designed to facilitate the capture of: Army public health nursing practice responsibilities, services, and metrics/trends; resource requirements; and a means of determining the impact of public health nursing services, including the risk to the military community if these services are not performed. The new instrument is based on national public health model standards included in the Local Public Health System Performance Assessment Instrument developed by the National Public Health Performance Standards Program (http://www.phppo.cdc.gov/nphpsp), and on other military and public health nursing standards. When completed, CHNs will be able to conduct a corporate-wide assessment of local level public health nursing services.

Family Nurse Practitioner Update by LTC Lorraine Carney

Greetings fellow Family Nurse Practitioners, it was great to meet many of you at the Annual Academy of Nurse Practitioners Conference (AANP) in June. This June at the AANP Conference we celebrated the 20th Anniversary of the AANP and the 40th Anniversary of NPs. It was also the final official Uniformed Nurse Practitioner Association (UNPA) meeting. Prior to this time the UNPA was a stand-alone association. We will now become a "Special Interest Group" within the structure of the AANP.

The UNPA fulfilled an honorable and useful service to hundreds of Uniformed Service NPs and CNMs in its 21 years of service. The organization transitioned due to a decline in membership, increased deployment of current members and the ability for the AANP to meet the benefit needs of the uniformed service NPs. For this reason it is recommended that the military NPs make the AANP their conference of choice for dialogue and networking.

We had two out-briefs which included the AD, NG and Reserve component. The breakouts were very well received. Overall enthusiasm and esprit de corps was profound. There were over 3000 NPs at the AANP conference and the Military NPs posted the colors, there were many positive remarks made during the general sessions expressing thanks to those in the military.

We realized the importance having the Reserve/National Guard and Active Duty component together. There was talk regarding communication via virtual means since every service member is on AKO, it may be the best form of communication. We will research this over the next few months.

There is concern that if we don't have a war time mission, potentially slots will disappear for Family Nurse Practitioners in the Army Nurse Corps. Considering the great potential utilization of FNPs in a war time setting, this would be a great loss. We need to show the army just how capable FNPs are, not only in routine clinic settings, but in trauma situations as well. **We are adaptable to the needs of the service**, no matter what they may be! Again I stress the need to go outside of your comfort zone and get more experience in ER, trauma and field medicine. The C4 course is ideal for all NP's and we should also all be certified in ACLS and TNCC at a minimum.

Don't forget our mission is to keep the fighting force strong at home and on the battlefield.

Perioperative Consultant- Registered Nurse First Assist Update by COL Keith Essen and CPT Carolyn Watson CRNFA

Two newsletters past we announced continued progress on the Registered Nurse First Assistant initiative (RNFA). Currently we have implemented a modest pilot initiative. I am pleased to announce that the credentialing mechanism is now in place. One individual has completed didactic training and will soon commence a clinical rotation with surgeons assigned to his Forward Surgical Team.

Over the course of the last twenty years many nurses have requested that the Army Nurse Corps enact a provision to accommodate the RNFA. Due to manpower constraints and other reasons this role was not embraced. Some Perioperative nurses expressed a desire to leave the service and pursue the RNFA role as a civilian nurse. Additional pressures exist at smaller MTFs to occasionally utilize either a technician or nurse in the first assistant role—but neither was credentialed.

Subsequent to 911 several reserve OR nurses were activated who had completed RNFA certification; however, the army had not yet embraced this new role, and did not have the credentialing mechanism in place. One officer, CPT Carolyn Watson is a Certified Registered Nurse First Assistant (CRNFA). She is helping us shape the RNFA concept so that it will fit into the current 66E role as an additional competency. We are proceeding cautiously to implement this initiative. Our intent is to incorporate this with minimal turbulence. In addition, COL Linda Wanzer is working a proposal to integrate a RNFA clinical elective for the Perioperative Clinical Nurse Specialist Program at the Uniform School University of Health Sciences.

Nursing and Surgeon support: RNFA credentialing is an additional skill set for the Perioperative Nurse—not an additional asset to the OR inventory. It is important that surgeon and nurse leadership understand this. Staffing depth varies from facility to facility on a day to day basis. A decision to leverage the RNFA asset is dependent on staffing and workload. The RNFA will work for the Perioperative Chief who will collaborate with physicians to determine staffing integration. Flexibility is crucial and essential to make this initiative work.

We are now actively seeking to identify individuals who are interested in pursuing the RNFA role. Certain requirements must be met, they are as follows:

1) Nursing leadership support at the respective MTF or Unit:
2) Surgeon support—clinical rotation requires surgeon mentorship.
3) Individual applicant must have CNOR certification and have proficiency in the scrub role.
4) Perioperative Chief must understand the role and its implementation within the constraints of current and projected assets—flexibility is key.

There are about 20-25 programs accepted by the Perioperative Certification Board (called The Competency and Credentialing Institute or CCI). Out of those, there are about 7 -10 that meet the ANC targeted criteria which are:

1. **Didactic is one week, 5-7 consecutive days** (some programs split it into 2 separate weekends one month apart and would require two TDY trips)
2. **Clinical Internship requires 120-150 hours of first assisting with a surgeon mentor**
3. **Cost is 1,200 to 2,500 for the complete program (not including books, or TDY for the one week).**

Programs vary when they are offered, whether once, twice or several times in one year. Most give up to one year to complete the clinical internship hours needed or one academic semester (about 4 months with extension if needed). Each program provides the guidelines and forms needed for documentation of hours and RNFA learning behaviors practiced during the clinical internship.

All programs accepted by the Certification Board require the nurse to have CNOR (specialty certification in OR), so the nurse wanting to attend a RNFA Program will be an experienced Perioperative Nurse with proficiency in scrubbing and circulating. Most vital is section support and surgeon support and ample opportunity to first assist, especially in the beginning when obtaining clinical hours during the internship. There should be a "by Name" surgeon mentor, but the student can first assist any surgeon who is willing to mentor them. The nurse anticipating attending a program should discuss this with their supervisors and surgeons they work with. Assisting different surgeons and in different specialties provides excellent experience for the First assistant.

Please direct interested candidates to COL Keith Essen, CPT Carolyn Watson, and LTC Michael Neft
Keith.Essen@na.amedd.army.mil
Carolyn.Watson@na.amedd.army.mil
Michael.neft@hoffman.army.mil

Calls for ….

A CALL FOR ARTIFACTS.

The Women's Memorial is developing a new exhibit to focus on women's service during Operations Enduring and Iraqi Freedom to be unveiled on Veterans Day. The Foundation is looking for pictures, artifacts and memorabilia, uniforms, and oral histories of women who served in Afghanistan and Iraq. Items can be donated or loaned for the duration of the exhibit. No item is insignificant in telling this story and can include anything from a set of orders or a load list for deployment, to an item purchased in a bazaar. Contact Lee Ann Ghajar, Curator of Exhibits at exhibits@womensmemorial.org or by calling 703-533-1155 or 800-222-2294 for more information about how to participate.

AONE 2006 ANNUAL MEETING AND EXPOSITION CALL FOR PRESENTATIONS

The American Organization of Nurse Executives (AONE) invites you to submit an abstract to present a breakout session or poster at the 39th AONE Annual Meeting and Exposition, scheduled for April 19-22, 2006 in Orlando, Florida. The AONE Annual Meeting and Exposition is **the** premier professional development and networking event for the nation's nurse leaders and those whose aspire to careers in nursing leadership. We look forward to your participation at the Annual Meeting and hope that you will share your knowledge and expertise with your fellow nurse leaders!

The submission deadline is **Monday, July 25, at 5:00 pm EST**. All abstracts must be submitted online using our online submission system, which can be accessed by clicking here or visiting the AONE Web site at http://www.aone.org/ and clicking on the 2006 Annual Meeting logo.

Please note that you will be asked to create a unique username and password for this site. You WILL NOT need your AONE member ID number to log in, nor should you use your AONE Web site member log-in information to access the submission site.

For 2006, we are seeking breakout session and poster presentations on the following topics that support the AONE Nurse Executive Competencies:

- Quality and patient safety initiatives
- Facility/workspace designs of the future, including use of technology
- Clinical Nurse Leader demonstration projects
- Programs addressing the aging workforce
- Cultural diversity
- Demonstrating value of nursing/ROI
- Education and practice initiatives
- Evidence-based clinical and management practice
- Critical access hospital issues
- Leadership and succession planning
- Career transitions
- State policy issues impacting national policy

If you have a technical question or problem with the submission system, simply click on the "Help" icon on the bottom of each page of the site. If you have other questions about the abstract submission process, please contact Stephanie Griffith, AONE education coordinator, at sgriffith@aha.org.

All abstract applicants will be notified by the end of September 2005 about the status of their submission(s).

Please share your expertise and knowledge with your fellow AONE members - submit an abstract for the 2006 Annual Meeting and Exposition!

News from the Army Nurse Corps Historian, LTC Charlotte Scott

Mark your calendar for this annual Military Order of the Purple Heart Service (MOPH) honoring military nurses at the Spirit of Nursing Memorial in Arlington National Cemetery located in Section 21 West of the Amphitheater on Porter Drive (historically known as "Nurses Hill"). This event is always held the second Friday in September at 2 p.m. This year's date is Friday, 09 September 2005. Seating will be available. A short program is held by the MOPH officers with remarks by military nurse corps chiefs or their representatives. A reception will follow at the Women in Military Service for America Foundation (WIMSA) on the grounds of Arlington Cemetery. Please RSVP to MOPH Office at (703) 642-5360 if you plan to attend.

News from Human Resource Command

From the Desk of the ANC Branch Chief – COL Roy Harris

June marks the beginning of the summer (05) rotations as assignments and RFOs materialize into the reality of actual moves for many of you. Even thought the optempo under GWOT requires some of us to move throughout the year, a majority of our Corps still moves during the summer rotation cycle. This supports many of our Corps who are married with children and ensures families can move together. That being said, I think it is important that all of our Corps understand the assignment philosophy embraced by Human Resource Command and being implemented throughout an Army at war as we prosecute the Global War on Terrorism (GWOT). We move (PCS) officers to authorized positions based on the needs of the Army and the priority is utilization of your specific skills and experience in open authorizations. You might think and say "we've always done it like that." Actually, until the advent of GWOT, the criteria for moving personnel weighed heavily in terms of individual officer needs (EFMP, compassionate, joint domicile, individual preference and high school stabilization). For the most part, career opportunities and skill utilization was considered within the context of individual officer needs. That paradigm has changed because the environment of GWOT requires us all to serve with an unwavering focus on the mission of our Army at war. Today's paradigm is one that gives priority to career opportunities and utilization of skills and experience as the first two reasons for PCS and individual officers needs now slips to number three in the criteria for PCS. Does this mean we DON'T integrate individual officer needs? Absolutely not. Truth be told, the majority of time we are able to coordinate joint domicile, high school stabilization, EFMP and other specific "quality of life" needs. But the reality of today's service in the Army will see many officers being asked to serve in assignments that do not meet geographical desires nor meet all of their individual officer needs. Clearly, as Army officers and professional nurses in our Army at war, we serve to meet the needs of the mission of GWOT and the GWOT road map, in the words of our leadership, is a long term road map focused on the demise of terrorism. We at Army Nurse Corps Branch will continue to aggressively work individually with our officers to manage their careers for optimal professional growth and service as well as resource our commanders for their organizational needs within the constraints of the personnel resources available to us. As summer gets underway, all of us here at Branch trust you will avail yourself of some much deserved time of rest and relaxation with your friends and family. Thanks for all you do for our Army at war, our AMEDD and our Army Nurse Corps.

RAH
Carpe Diem!

News from the AMEDD Center & School

NEWS FROM THE DEPARTMENT OF NURSING SCIENCE (DNS)
ACADEMY OF HEALTH SCIENCES
AMEDD CENTER & SCHOOL
CHIEF, COL PATRICIA A. PATRICIAN
NCOIC, MSG RONALD POLITE
(210) 221-8231

MESSAGE FROM THE CHIEF, DNS

Greetings from DNS! As many of you might know, DNS has oversight of education and training for all AN AOC and ASI Courses (except 66B and 66P); AN leadership courses; AN tracks in BOLC and CCC; the 91WM6 Program and the 91D Program. We do not train 91Ws in DNS – that is accomplished by a different department, the Department of Combat Medic Training. Most of this education and training in the nursing related career fields is conducted at the medical treatment facility (MTF) level. With the exception of the year-long Anesthesia Phase I Program, the time students spend at the Academy is relatively short. In fact, both the 91WM6 Phase I and the 91D Phase I are less than 10 weeks in length. Thus, we rely heavily on the MTFs to train our AN officers, LPNs, and OR Technicians. Nursing or Hospital Education commonly "owns" these programs and we work very closely with Nursing/Hospital Education Chiefs, the AOC Course Directors, and Phase II Directors to ensure education is standardized and students are afforded every opportunity to succeed. To all the educators at the MTFs, a sincere Thank You for all that you do to train the future of the AMEDD.

MSG Polite and I returned recently from a site visit to Eisenhower Army Medical Center (EAMC), where DNS has three Phase II training programs: Anesthesia, 91WM6, and 91D. The hospital, nursing, and educational leadership have made great strides in setting the standard for Phase II education and training and we were impressed with their strong commitment to the students' academic success and quality of life. The Anesthesia faculty gave me every indication that their Phase II training program was one of the best in the AMEDD. The M6 students made laudatory comments about their Phase II faculty and clinical experiences. The 91D students we interviewed were so grateful for and enthusiastic about their training, they felt ready to practice and even to deploy.

I would like to publicly acknowledge COL Doris Johnson, Chief, Hospital Education, for ensuring availability of resources for all programs, professional development opportunities for Phase II faculty, and staffing the 91D Program with a dedicated instructor and preceptor. Her efforts have markedly improved Phase II training at EAMC.

A special thanks to our escort MSG Marcelline Theodore, NCOIC of the 91WM6 Phase II Program at EAMC. Best wishes to her as she transitions to 1SG, Student Company, EAMC.

Personnel Changes

This month, we say farewell to LTC Susan Anderson, Deputy Chief, DNS, who is retiring after 20 years of exceptional service to the AN. LTC Kim Armstrong, who is currently on a training mission in Lebanon, will move into the Deputy Chief position next month. The AN Professional Development Branch welcomes its new Chief, LTC Justin Woodhouse, and the new Officer Basic and CPT's Career Course Liaison, MAJ Anthony Bohlin. MAJ Cheryl Brown is PCSing to Spokane, WA. MAJ Jennifer Hines, 91WM6 Branch, will be trading places with MAJ Karen Hutchinson from the 91W Program. CPT Corey Ramsey joined our 91WM6 Program as well. SFC Chase assumed the NCOIC, 91WM6 Phase 1 position from SFC Kemplin.

Deployments

LTC Susan Anderson and MAJ Brian Benham have returned from Afghanistan and LTC Tim Newcomer has returned from Honduras. LTC Kim Armstrong is currently on a training mission in Beruit, Lebanon. Please see the news piece written by LTC Anderson and MAJ Benham in this issue of the Newsletter.

New DNS Building

The design phase of the new Department of Nursing Science building is 90% complete. The building will consolidate classroom and practical exercise space for the Anesthesia, 91D, and 91WM6 Programs, and house all faculty offices. A large conference room was incorporated into the plans to host the Head Nurse Course and others conferences. A ground breaking ceremony is planned for this fall. We intend to name the new building Dunlap Hall, for the former Corps Chief, BG Lillian Dunlap. BG Dunlap was very involved in education, worked steadfastly on the BSN requirement for entry into the AN, and was a native of San Antonio. The scheduled completion date for the building is Summer 2007.

POC for Transcripts/Certificates

Can't find your Instructor Trainer Course Certificate from 12 years ago?? (Been there.) Just contact the AMEDDC&S Registrar, **Ms. Christina Litzler** at (210) 221-6207, DSN 471 if you need a transcript or course completion certificate. She is also on Outlook. She will need your name, SSN, course name, approximate course dates, and a good mailing address.

ANESTHESIA BRANCH
CHIEF, COL NORMA GARRETT
NCOIC, SSG MONTEZ BONNER

Sigma Theta Tau Inductees

The DNS is proud to announce the latest inductees into the Zeta Pi Chapter of *Sigma Theta Tau* International Honor Society of Nursing at the University of Texas Health Science Center at Houston in May 2005. The following 12 graduate students in the US Army Graduate Program in Anesthesia Nursing (USAGPAN) have maintained at least a grade point average of 3.5 and meet all expectations of academic integrity: 1LT(P) Arredondo, CPT Warren Day, CPT Angela Downs, CPT Jimmie Foster, CPT Mary Hannon, 1LT(P) Neil Hurd, Capt Jeffrey Jednyak, Capt David Johnson, MAJ Richard Reid, Capt Scott Sanders, Capt Timothy Shaw, and MAJ Pamela Wulf.

Ten faculty members of the USAGPAN demonstrating excellence and leadership were also inducted as "Community Nurse Leaders" and include: LTC Nathaniel Apatov, MAJ Brian Benham, Dr. Douglas Christie, LtCol Marilee Edwards, COL Normalynn Garrett, LtCol Donna Heiter, Mr. Robert Lloyd, MAJ Daryl Magoulick, CPT(P) Cybil True, and Ms. Kathleen Winger.

Congratulations to you all!

Welcome New Students

The USAGPAN welcomes the Class of FY 05. These 37 nurses (29 Army, 3 Air Force and 5 Department of Veteran's Affairs) are the latest example of the high caliber nurse clinicians who choose to increase their responsibility and autonomy by training to become Certified Registered Nurse Anesthetists (CRNA). In addition, the Class of FY 04 have embarked to their clinical instruction sites. There, they will have the honor and privilege of caring for the best group of patients…our Soldiers, Sailors, Marines and Airmen, and all other beneficiaries of the Department of Defense health care system. Both of these groups of students will do great things, and we're very proud of them.

If you'd like to know what it takes to be like the officers mentioned above, contact COL Normalynn Garrett, AN, the Program Director for the USAGPAN, at 210-221-7311 or via e-mail at norma.garrett@amedd.army.mil. You could also seek out a CRNA at your hospital or unit and ask them about their profession. Additionally, you can access our web site at http://www.dns.amedd.army.mil/crna/. In case you have not heard, the incentive specialty pay for CRNAs has increased in the last year. There are 48 available slots reserved for the Class of FY 06, the next generation of CRNAs. Will you be one of them?

91WM6 (PRACTICAL NURSE COURSE) BRANCH
CHIEF, LTC PATRICIA LEROUX
NCIOC, SFC DAVID GRAHAM

91WM3

Thanks for all your support for the Dialysis Tech Course. We are pleased to announce that the class that begins in June is full to capacity with 8 students. Because this is a critically short ASI, we are planning to hold an additional course in January 2006. The E-5(P) rank is no longer a restriction and does not require a waiver.

NCLEX Failures

Just as a reminder, all 91WM6s take the NCLEX exam while they are still in the program. Although our first time pass rate is 96%, there are soldiers who fail and must retake the exam. According to DA PAM 611-21, Soldiers who fail the exam twice or who are not licensed within one year need to be reclassified. They need to have their M6 removed. This is accomplished by completing and sending a DA 4187 to AMEDD Personnel Proponent Directorate, AMEDDC&S. If Soldiers do not take the exam within four years of their educational program completion date, they will no longer be eligible to test in TX.

Assignments for 91WM6s

The 91WM6 Process Action Team has been meeting for about a year now. One of the issues identified was that 91WM6s were being assigned at the installation level as 91Ws. In order to stop this practice, SGM Mullins from FORSCOM has been working with the installation G-1s. Here is a message that is forthcoming in the AG Newsletter for all installation G-1s: "Some Soldiers in MOS 91W have an Additional Skill Identifier of M6 (Licensed Practical (LPN) or Licensed Vocational Nurse (LVN)). It has come to the attention of the FORSCOM Surgeon's office that some installations are assigning these soldiers to generic 91W positions. Please note that these Soldiers go through a very vigorous training program that's about one year in length as compared to the 91W which is 16 weeks. Soldiers with the M6 ASI have two licenses to maintain. One is their LPN/LVN licensure for M6 and the other is the National Registry of Emergency Medical Technicians (NREMT) which all 91Ws must maintain. Often, the Continuing Education (CE) requirements to maintain their licenses cannot be attained at the unit level and therefore, the M6 Soldiers must be sent to the MEDDAC, MEDCEN, Combat Support Hospitals (CSH), and or other training facilities to gain access to these requirements. If the Soldier fails to maintain their NREMT or their LPN/LVN licenses they are subject to reclassification actions. One problem which has been addressed with HRC is the fact that assignment orders do not indicate the M6 ASI in the MOSC. I would ask that your personnel clarify the ASIs for inbound 91Ws and assign them accordingly."

OPERATING ROOM SPECIALIST (91D) COURSE
CHIEF, LTC JOHN AUSTIN
NCOIC, SFC ROCHELL PETERMAN

On Monday, 20 June, 2005 our second 91D Operating Room Specialist Course, Phase 2 class, graduated from the Audie Murphy Veterans Administration Medical Center (VAMC) in San Antonio. The eight students had ten weeks of clinical operating room experience that included specialties ranging from general surgery to vascular and orthopedic specialties. As a result of this partnership, the Audie Murphy VAMC is a training leader for the 91D program, graduating more 91D students per cycle than most other training facilities. This is truly a DoD/VA success story!

ARMY NURSE CORPS PROFESSIONAL DEVELOPMENT BRANCH
CHIEF, LTC KIMBERLY ARMSTRONG

Farewell from MAJ Cheryl Brown

I want to take this time to thank almost one thousand AN junior officers for allowing me the opportunity to teach, coach, mentor, and interact with you during my past 2 years as the OBC/OAC/CCC Nurse Liaison at the AMEDD Center and School. This position has been most rewarding. I am very proud of the quality of officers that are making brave decisions to come into the ANC. My family and I are PCS'ing to Spokane, Washington 1 August 05 to be the Assistant Chief Nurse of the 396th CSH.

I can be reached through AKO at cheryl.brown1@us.army.mil My cell: 240-277-6072.

It's been a pleasure contributing to your AN education. I am available for continued mentoring and counseling as you pursue your career and future.

Please take care of yourselves as you spread out around the world.

Guidelines for Mobilized Reservists to Receive Funding to Attend the Head Nurse Leadership Development Course (HNLDC)

The process to attend the course has recently changed and mobilized reservists should follow these guidelines for submitting a packet in order to receive funding:

1. HRC-St. Louis will ONLY fund mobilized reservists (CONUS only) to attend the HNLDC if they are currently serving in a Head Nurse position.

2. HRC-St. Louis will NOT fund mobilized reservists that are OCONUS.

3. For the application process, the nurse and Hospital Educator should follow the guidelines at this website except as annotated in statement 4:
https://www.hrc.army.mil/site/reserve/soldierservices/guidance/pdeheadnurse.htm

4. **Please disregard the below statement on the website.** It is incorrect and will be updated shortly by HRC-St. Louis.
USAR Mobilized Army Nurse Corps Officers:
*a. Mobilized AN's wishing to attend the HNLDC are directed to resource their Active Component chain of command for approval process and quota source management (**Remember – this is incorrect as the website has not been updated**).*
*B. Mobilized AN's are not required to submit a packet to HRC, St Louis for boarding approval and course admission (**Remember – this is incorrect as the website has not been updated**).*

5. All Mobilized Reservists must follow the guidelines on the website and **ARE** required to submit an application packet to HRC-St. Louis. A letter from the MTF Chief Nurse must be submitted with the application packet recommending the reservist's attendance at the course and a statement attesting that the reservist is serving in a Head Nurse position.

6. Please note that the deadline for application packet submission is 90 days prior to course start date and that the selection board for each course convenes 60 days prior to the course. Upcoming Course Dates are as follows.

Report Date	Start Date	End Date
5 JUN 05	6 JUN 05	17 JUN 05
7 AUG 05	8 AUG 05	19 AUG 05
16 OCT 05	17 OCT 05	28 OCT 05
22 JAN 06	23 JAN 06	3 FEB 06
2 APR 06	3 APR 06	14 APR 06
4 JUN 06	5 JUN 06	16 JUN 06
6 AUG 06	7 AUG 06	18 AUG 06

7. **SOLDIERS NOT SUBMITTING A PACKET TO THE HNLDC BOARD WILL NOT BE CONSIDERED TO ATTEND.**

The Program Director for the HNLDC is MAJ Kelly Bramley. DSN 471-6080 or commercial (210) 221-6080. Email to kelly.bramley@us.army.mil.

Office of the Chief, Army Nurse Corps	
Fort Sam Houston Office COL Barbara Bruno, Deputy Chief ANC mailto:Barbara.bruno@amedd.army.mil LTC Sheri Howell, AN Staff Officer mailto:Sheri.howell@amedd.army.mil MAJ Eric Lewis, AN Fellow mailto:Eric.lewis@amedd.army.mil AMEDD Center and School ATTN: MCCS-CN, Room 275 2250 Stanley Road Fort Sam Houston, TX 78234 210.221.6221/6659 DSN 471 Fax: 210.221.8360	**Washington, DC Office** LTC Karen Whitman, AN Staff Officer mailto:Karen.Whitman@belvoir.army.mil Headquarters, DA Office of the Surgeon General 6011 5th Street, Suite #1 Fort Belvoir, VA 22060-5596 703.806.3027 DSN 656 Fax: 703.806.3999
ANC Branch @ HRC: www.perscomonline.army.mil/ophsdan/default.htm	AN Website: http://armynursecorps.amedd.army.mil/